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Status of Clinical Supervision Among School Counselors in Southeast Georgia

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Abstract

Previous studies have investigated the role of clinical supervision in school counseling practice. This research explored the status and meaning of clinical supervision to school counselors employed in two southeastern Georgia counties. Results indicate that participants value clinical supervision even though their employers did not necessarily support their efforts to access supervision.

Keywords: clinical supervision and school counseling; clinical supervision and school counselors; clinical supervision

"Counselors in training during graduate school studies experience practicum and internships in order to develop basic competencies in the clinical skills of counseling. Clinical supervision, viewed as one of the most important pedagogical practices used in these training experiences, is one of the ways future professional counselors gain feedback and direction for further improvement and maintenance of these counseling competencies" (Ehrmann, 2003).

The above statement and the American Counseling Association (ACA) Code of Ethics (ACA, 2005) both make the point that supervision, particularly *clinical* supervision is an excellent tool used to help counselors learn and maintain basic competencies. If ongoing clinical supervision shapes counselor trainee effectiveness, then ongoing clinical supervision of professional school counselors should continue to support optimal professional functioning in the work environment. Further, if clinical supervision is

an essential tool for counselor development, then to what extent do professional school counselors receive clinical supervision? If not, what barriers impede receipt of this valuable tool? Finally, how important do professional school counselors hold clinical supervision as necessary for their ongoing professional development?

Statement of the Problem

At least three prior studies have used the above questions to query counseling professionals over the last two decades (Page, Pietrzak, & Sutton, 2001; Roberts & Borders, 1994; Sutton & Page, 1994) and comprise the focus of this study. Specifically, the researchers sought to document the current state of supervision for employed school counselors in two southeastern counties in Georgia, with the hypothesis that at least 25% of the population surveyed would be currently receiving supervision. Further, the researchers sought to determine school counselors' desire for supervision, with the hypothesis that at least 50% of the surveyed population would desire or feel that they would benefit from clinical supervision. Lastly, the researchers sought to determine what factors might aid or hinder obtaining supervision, with the hypothesis that factors hindering supervision would have decreased since the prior studies. The study attempted to assess participants' attitudes toward a set of selected goals derived from a set of domains for counselor supervision developed by Stoltenberg and Delworth (1987). These goals addressed eleven common areas of supervision. The researchers hypothesized that the three main goals listed as important to counselors would have changed since the previous studies due to changes in work conditions and expectations in the field of school counseling since the last study in 2001.

Review of the Literature

Most of the literature on school counselor supervision consists primarily of state-level surveys (Roberts & Borders, 1994; Sutton & Page, 1994). In 1994, Sutton and Page designed a questionnaire and sent surveys to 533 Maine school counselors to establish their use of supervision. Their study found that only 20% of the 493 respondents received clinical supervision even though 48% desired supervision as a viable aspect of professional development. Among the 80% who did not get supervision, 37% indicated that they felt no need for supervision. When asked to identify major barriers to obtaining clinical supervision, the most common response from the counselors was that they did not have knowledge about how to arrange for supervision for themselves after graduate school. Page, Pietrzak, and Sutton (2001) investigated supervision practices among 267 American School Counselor Association members in the state of Maine. Although there were slight increases in the percentage of school counselors receiving some form of clinical supervision, 47% of the surveyed school counselors were not receiving clinical supervision of any kind. Moreover, even though the majority of the school counselors indicated that they wanted this experience for professional development, 33% of the surveyed respondents indicated that they did not want to receive clinical supervision.

Unfortunately, earlier literature on supervision of school counselors reveals a paucity of research (American Association for Counseling and Development [AACD], 1989) and the apparent lack of practice (Borders, 1991; Roberts & Borders, 1994; Boyd & Walter, 1975). The school counseling task force of the AACD (now American Counseling Association [ACA]), stated, "Essentially, proper supervision of school counselors is lack at best, non-existent at worst" (AACD, 1989, P.20). Since the national study by Page, Pietrzak, and Sutton (2001), few researchers have addressed their findings. Thus, lack of supervision may affect many areas of school counselors' job performance and satisfaction.

Impact of Unprepared School Counselors on Student Success: Mental Health Issues

Although the specifics of supervision among practicing school counselors has been very limited in the research, other areas impacting counselor's work environments and support needs have been addressed in the review of the literature for this investigation. Several studies have questioned the need for either more support or training for school counselors working in the current school systems of today.

School counselors can support teachers by providing classroom strategies that meet the learning and personal/social needs of students in crisis and which support

teachers' as they cope with the crises too. Providing such support and intervention requires consultation and collaboration skills that Master's degree programs did not make available. Clinical supervision provides a way to develop needed skills (Bernard & Goodyear, 1998). Counselors, however, frequently work without the benefit of clinical supervision and often work in unsupportive environments (Sutton & Page, 1994). For many years, supervision of school counselors was an over - looked professional issue (Barret & Schmidt, 1986).

Another area of concern is the mental health needs of at risk students in school. Often, the first line of involvement is with the school counselor. Students fail to be successful in school everyday due to conduct disorders and hindrances to success such as Attention Deficit Hyperactivity Disorder (ADHD) or less noticeable symptoms such as depression and Post Traumatic Stress Disorder (PTSD). Many of today's students grow and develop in environments characterized by poverty, substance abuse, child abuse, family instability, and domestic and community violence (Kirst, 1991; Weist, 1997). Children living in geographical regions that have limited community counseling services may have unmet counseling needs that fall on the school system. Without ongoing clinical supervision, how do counselors address students' unmet counseling needs? Limited supervision might impede counselors' ability to recognize certain clinical conditions and orchestrate appropriate referrals or interventions.

A Counselors' Reality: Poverty and Crisis among Public School Students

As mentioned above, numerous factors put students at risk for academic failure or dropping out of school. Keys, Bemak, and Lockhart (1998) state that school counselors have an important part to play in helping schools respond to the increasing number of students whose mental health needs place them at risk. Two primary factors in the lives of students who are at risk for failure and drop out include poverty and emotional crisis.

Kazdin and Johnson (1994) noted that prevalence studies indicate that between 17% and 22% of youth less than 18 years of age suffer developmental, emotional, or behavioral problems. Costello et al. (1996) had similar findings that 20.3% of children between the ages of 9 and 13 met the criteria for mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). These disorders may range from depression, anxiety, PTSD, oppositional defiant disorder, or conduct disorder. Most researchers and clinicians would agree that there is a probable link between depression and other mental health issues, and achievement scores and overall school success (Kirst, 1991; Weist, 1997). However, an important point to note is that many of these students will not meet the criteria for placement in special education. That these students will not necessarily qualify for extra support places the brunt of their support needs solely on the counselors and teachers.

School Counselors, Defacto Mental Health Workers

School counselors encounter complicated cases in which students have acute counseling needs on a regular basis (Borders & Drury, 1992). The National Institute of Mental Health (NIMH) concluded that without treatment for these students, their schoolwork may suffer, disruption of normal family and peer relationships can occur, and students may engage in violent acts. Counselors often function as the sole mental health professionals able to assist such students, yet they find themselves without the support of regular supervision (Barret & Schmidt, 1986). Typically, conventional approaches instruct school counselors that such cases lay beyond the scope of their training and that these students should be referred (Gysbers & Henderson, 1988). Although this may be true, such methods fail to address fully the needs of these students and counselor responsiveness. The reality is often the school counselor is usually still responsible for children even when these students receive or need outside services.

Although many students receive outside counseling, the school counselor is often called on to manage disruptive or dangerous behaviors that emerge in school, as well as consult with parents and teachers regarding student counseling issues, learning difficulties, or the effects of medication. In addition, the counselor may receive requests to provide counseling to complement the community-based services or to provide counseling if community-based services are not available or not used. Some school

counselors may provide brief therapy for students on campus but may feel that this is either not a prescribed role or a role outside of their training (Brown, 1989; Coll & Freeman, 1997). Dissonance about counselor roles may lead to questions regarding the type of training and supervision school counselors receive. Further, counselors may wonder how this training prepares them to counsel students who need intensive interventions.

Methodology

Participants

This was a descriptive study assessing the current practice of clinical supervision in school counseling in two southeastern Georgia counties. The participants included all school counselors, elementary, middle, and high, listed as currently working in the public school systems of two southeastern Georgia counties. This number included all counselors (n=129) in these public school systems as well as all high school vocational counselors. Participants did not identify as graduation coaches or private school counselors. The participants voluntarily completed and returned the questionnaires. The researchers did not collect demographic information to ensure anonymity for the respondents.

Instrumentation

Researchers distributed a survey used by Page, Pietrzak, and Sutton (2001) in a national survey of counselor supervision. The primary question on the survey asked, "Do you feel that you would benefit from clinical supervision?" Second, the survey queried, "Is clinical supervision available to you?" Third, researchers solicited the number of counselors receiving and expressing a belief that they would benefit from clinical supervision. In addition, the survey instrument solicited information on (a) current clinical and administrative supervision, (b) participants' perception of the importance of selected supervision goals, and (c) participant's reasons for not receiving supervision. Participants received the following definitions to guide survey completion:

- ***Administrative supervision*** is an ongoing process in which the supervisor oversees staff and staff communications, planning, implementation, and evaluation of individuals, programs, or both individuals and programs.
- ***Clinical supervision*** is an intensive, interpersonal focused relationship, usually one-to- one or small group, in which the supervisor helps the counselor as he or she learns to apply a wider variety of assessment and counseling methods to increasingly complex cases.
- ***A clinical supervisor*** is a licensed mental health professional counselor, social worker, or psychologist who has at least 5 years of experience in the field.

Supervision goals were rated on a Likert scale with: 1 = not important, 2 = minimally important, 3 = somewhat important, and 4 = very important. The survey contained ten items designed to elicit information about supervision currently received by the counselor; the counselor's interest in supervision as a future aspect of professional development; four questions on factors that might hinder or facilitate efforts to obtain supervision; and eleven Likert-type items assessing attitudes about the importance of a set of supervision goals.

Procedure

A questionnaire was mailed to every public school counselor listed as currently employed by two southeastern Georgia county school boards. Researchers constructed the mailing list by counting all school counselors listed for the two counties by the Georgia Department of Education. Next, researchers separated the list of schools by county and included all elementary, middle, high, and alternative schools. Every counselor listed for the schools in their respective counties received a survey through the mail. The packet also contained a cover letter, a copy of the survey (Appendix A), and a return self-addressed stamped envelope. The cover letter provided information about the purpose of the study and asked for voluntary participation. Researchers sent a survey to every school counselor in both counties and followed up with an email two weeks after the initial survey to remind counselors of the survey and to repeat the request for voluntary participation.

Results

Researchers calculated descriptive statistics for each survey question. Due to the slight differences between this and previous versions of the questionnaire, the researchers did not calculate comparisons among like items from the three prior studies discussed in the literature review.

Out of the 129 surveys sent out 40 (31%) were returned. This response rate represents approximately one third of the sample and meets most recommendations for survey response research. The first hypothesis maintained that the majority of school counselors continue to desire clinical supervision and receive supervision. Because only 5% (*N*=2) of the participants reported receiving supervision, researchers rejected the first hypothesis, which posed that at least 25% of the sample would report receiving current supervision. In this study 68% (*N*=26) of the respondents reported potential benefits from supervision. Consequently, the researchers accepted the second hypothesis, which posed that at least 50% of the surveyed population desired or perceived a potential benefit from clinical supervision. Researchers found no support for the third hypothesis, which sought to determine the factors that might aid or hinder obtaining supervision. Neither county nor school districts offered any clinical supervision. Seventy-one percent of the respondents (*N*=27) said that they would seek clinical supervision if offered by their school systems. Other reasons given for not receiving supervision (besides not being offered by their employer) included 63% (*N*=24) who indicated that they did not know how to obtain supervision; 18% (*N*=7) stated that they did not have the time; and 8% (*N*=3) said that the American School Counseling Association (ASCA) does not endorse supervision.

In addition to these three hypotheses, the survey attempted to assess the participants' attitudes toward a set of goal statements developed for counselor supervision by Stoltenberg and Delworth (1987). These goals covered eleven common areas of supervision. Researchers hypothesized that the three main goals listed as important to counselors would have changed since the previous studies listed in the literature review. The reason for the hypothesized change would be due to changes in work conditions and expectations in the field of school counseling since the last study in 2001. The researchers rejected this hypothesis. The top three rated goals in clinical supervision in order of importance were (a) Understanding Psychotropic Medications, 97% (*N*=37), (b) Taking Appropriate actions with Client Problems, 87%, (*N*=33) and (c) Developing Skills and Techniques, 87%, (*N*=33). These results were very much in line with previous research findings. Counselors in the 2001 National Survey and in the 1994 Maine study rated two of the same goals as most important for clinical supervision: taking appropriate action with client problems and developing skills and techniques.

Discussion

Conclusions and Implications

This study utilized survey data to determine the role of clinical supervision in the professional experiences of school counselors employed in southeastern Georgia counties. The secondary effort of the study also reviewed data to determine the percentages of counselors wishing to receive supervision and factors relating to that concern. In this survey, only 5% of polled counselors responded that receiving such supervision, although the percentage of counselors desiring supervision was in the 60% range.

In the Sutton and Page (1994) study, while 63% of the respondents reported desiring supervision, only 20% received the opportunity. Page, Pietrzak, and Sutton (2001) concluded that only 23% of counselors reported receiving clinical supervision. Although not feasible to compare directly the two earlier studies with the current study, similarities seem to exist. One emerging trend might indicate less school support for supervision, rather than more given only 5% of the counselors polled in this study receive clinical supervision. That either of the two counties polled do not offer supervision may indicate the school system's failure to keep pace with national and state professional trends. If the need and desire exists as indicated in these three studies, why is the counseling field making so little progress in providing clinical supervision for professional school counselors? Moreover, a review of the literature suggests that stakeholders expect school counselors to manage the mental health aspect of students who have unmet or undiagnosed mental health needs. Therefore, based on the results of this survey, professional school counselors may not feel equipped to handle this shift in responsibilities. School counseling has a history of change based on social conditions (Paisley & Borders, 1995). Given the complexity of needs today's students face, traditional school counseling methods may not be effective in assessing counselor effectiveness and planning counselor responsibilities. Keys, Bemak and Lockhart (1998) write that classroom guidance, the backbone of the school counselors' primary prevention effort and main vehicle for life skills development has been criticized for

failing to produce long term results with at risk populations. Some have described classroom guidance as too broad in scope and unable to address fully the needs of failing students (Dryfoos, 1990; Webster, 1993; Weissberg, Caplan, & Harwood 1991). A positive move in supporting school staff and students is the institution of Response to Intervention (RTI). Educators interpret and deliver RTI differently from district to district and even from school to school. However, the focus of having a multi-disciplinary team to review data and to develop strategies for support and success remains the same. This model should ease the burden of the sole counselor in the school setting. The school counselor can be a very helpful person to have on this interdisciplinary team. In order to be able to provide the team with informed best practices for helping students, ongoing counselor development must occur. School counselors need to be more clinically sound if they are to meet the challenges of the ever-demanding communities in which they work.

Recommendations

The researchers recommend that school districts consider providing or at least allowing release time for school counselors to receive clinical supervision in a group model or through peer support groups. Counselors often serve as the sole mental health professionals available to assist students, yet they find themselves without the support of regular supervision (Barret & Schmidt, 1986). However, as reflected in the results of the present study, the need for supervision may be growing although the support of available supervision has not kept pace.

Although the introduction of the Response to Intervention (RTI) model may improve the interdisciplinary support and communication, RTI will not remove the counselor as the primary staff person relied on as responsive support for all nature of crisis outside of the special education department. The school counselor is often the default staff person elected to provide responsive and crisis, services to students during the RTI process. Before students obtain referral for special education services, their behavior and emotional needs fall under general education services, one domain of the school counselor duties. Furthermore, many students with conduct and other behavioral problems will not qualify for special education but still require ongoing support. All of these factors contribute immensely to being at risk for failure and drop out. Counselors must counsel with students as part of the students‘ school plans, in addition to whatever outside counseling supports they are receiving.

A second recommendation offers that ASCA directly and more emphatically addresses the needs of supervision for school counselors, supporting the professional need for clinical supervision. ASCA and affiliated state associations can support counselors‘ need for supervision by creating a strong role/position statement (Van Zandt & Hayslip, 1994). Specifically, ASCA and the Georgia School Counselor Association (GSCA) need to promote state legislation that mandates clinical supervision of school counselors in Georgia as a professional in-service and re- certification requirement.

Finally, recommendations to improve the research design of this study would include returning the demographic data questions to the survey instrument. The removal of the demographic questions made it impossible to gauge the differences in counselor career stages and the possible needs among the three different components of school counseling, elementary, middle and high school. Differences in communities needs such as rural versus urban might be captured as well by expanding the demographic data. Because of the limitations of the current instrument and the population sampled, we cannot draw any conclusions about the needs of urban schools, elementary, middle, and high as they differ from smaller towns or rural environments. Although this would be a much larger undertaking, an instrument listing clear demographic questions such as age, gender, highest educational level, and area of school counseling would help very much to get a larger picture of why counselors might have responded as they did. Random sampling counselors across the entire state of Georgia would provide information about rural, urban, and suburban areas.

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Appendix A

Questionnaire

1. Do you feel that you would benefit from clinical supervision?

68%	Yes	(N=26)
32%	No	(N=12)

2. Is clinical supervision offered by your school district?

Neither _____nor _____County schools Systems offer clinical supervision.

3. If you answered yes is there a fee:

68%	Blank/No answer	(N=27)
18%	No	(N=7)
11%	N/A	(N=4)

4. If you answered yes there is a fee does the school pay for it?

18%	No	(N= 7)
11 %	N/A	(N=4)
71%	Blank	

5. Is access to clinical supervision available in your town or community?

50%	Yes	(N=19)
21%	No	(N=8)
21%	Unsure or Don't know	(N=8)
8%	Blank	(N=3)

6. Are you currently receiving clinical supervision?

5%	Yes	(N=2)
95%	No	(N=36)

7. Have you received clinical supervision in the past?

21%	Yes	(N= 8)
79%	No	(N=30)

8. Are you currently receiving administrative supervision?

45%	Yes	(N=17)
53%	No	(N=20)
3%	Blank	(N=1)

9. If you have ***no interest*** in receiving clinical supervision:

26 %	"Do not feel that it is necessary"	(N=10)
16%	"Do not feel that school counseling has clinical needs"	(N=6)
<1%	"Do not have ready access to clinical supervision"	(N=1)
18%	"Do not have time to receive clinical supervision"	(N=7)
8%	"Not endorsed by the ASCA model"	(N=3)

10. Please list reasons why you are not receiving clinical supervision:

Various handwritten answers

11. Is release time a factor in not receiving clinical supervision?

37%	Yes	(N=15)
52%	No	(N=21)
1%	Blank	(N=4)

12. Is financing of supervision cost a factor in your not receiving supervision?

40%	Yes	(N=15)
52 %	No	(N=20)
<1%	N/A	(N=1)
1%	Blank	(N=4)

13. Do you know how to obtain clinical supervision in your community?

37 %	Yes	(N=14)
63%	No	(N=24)
<1%	"Don't want it"	(N=1)
<1%	Blank	(N=1)

14. If clinical supervision was available to you at no cost and supported by your school would you attend?

71%	Yes	(N=27)
29%	No	(N=11)
<1%	Maybe	(N=1)
<1%	Blank	(N=1)

Importance of Supervision Goals to School Counselors

Goals:

1. Taking appropriate action with client problems

0%	Least important	(N=0)
5%	Somewhat important	(N=2)
21%	Very important	(N=8)
66%	Most important	(N=25)

2. Developing skills and techniques

<1%	Least important	(N=1)
0%	Somewhat important	(N=0)
26%	Very important	(N=10)
61%	Most important	(N=23)

3. Formulating a treatment plan with long and short term goals

8%	Least important	(N=3)
11%	Somewhat important	(N=4)
37%	Very important	(N=14)
32%	Most important	(N=12)

4. Ability to use own reactions/emotions diagnostically

3%	Least important	(N=1)
8%	Somewhat important	(N=3)
42%	Very important	(N=16)
24%	Most important	(N=9)

5. Integrating professional ethics into ongoing counseling practice

<1%	Least important	(N=1)
11%	Somewhat important	(N=4)
32%	Very important	(N=12)
48%	Most important	(N=18)

6. Developing independence/self-directedness

3%	Least important	(N=1)
16%	Somewhat important	(N=6)
24%	Very important	(N=9)
45%	Most important	(N=17)

7. Developing sense of self as a counselor

8%	Least important	(N=3)
18%	Somewhat important	(N=7)
37%	Very important	(N=14)
39%	Most important	(N=15)

8. Developing awareness of personal motivation

5%	Least important	(N=2)
24%	Somewhat important	(N=9)
34%	Very important	(N=13)
32%	Most important	(N=12)

9. Developing respect for individual differences

8%	Least important	(N=3)
16%	Somewhat important	(N=6)
29%	Very important	(N=11)
47%	Most important	(N=18)

10. Understanding student‘s psychiatric diagnosis

3%	Least important	(N=1)
11%	Somewhat important	(N=4)
29%	Very important	(N=11)
55%	Most important	(N=21)

11. Understanding psychotropic medications

5%	Least important	(N=2)
18%	Somewhat important	(N=7)
34%	Very important	(N=13)
63%	Most important	(N=24)